

MEDICAL CONTROL COMMITTEE

MINUTES

March 16, 1999

<u>Members Present:</u>	<u>Others Present:</u>
Ed DesChamps, MD, Chairman	Joseph Fanning
John Sorrell, MD	Phyllis Beasley
Bill Gerard, MD	Tekethia Washington
Richard Rogers, MD	Robert Mearns, MD
Doug Norcross, MD	Kelly Hawsey
Bob Malanuk, MD	Lewis Moore
Carol Baker, MD	
Ron Fuerst, MD	
Steve Shelton, MD	

MINUTES FROM 12/3/99

The first item on the agenda was the review/discussion of the minutes from the last Medical Control Committee meeting on December 3, 1998. **Dr. Norcross made a motion to accept the minutes as presented. The motion was seconded by Dr. Sorrell. All were in favor. The motion passed.**

Dr. DesChamps informed the Committee that Dr. Steve Shelton has been named as the American College of Emergency Physician's (ACEP) representative.

DRUG LIST CHANGES

CCEMS Toxicology Drug Box

Dr. Sorrell informed the Committee that Charleston County EMS is currently training a team of 15-20 paramedics to a *HazMat Medical Specialist* level. The training is similar to that of the Arizona Department of health (Tox-Medic certification program) and the City of New York fire

department Division of EMS. Dr. Sorrell stated that the curriculum has been adapted from the National Fire Academy's programs in Hazardous Materials, EMS, and Terrorism. Dr. Sorrell further explained that paramedics will receive training in chemistry, toxicology, patient decontamination, treatment of patients while utilizing chemical protective clothing, medical monitoring, and critical incident debriefing.

The **Tox Box** combination of drugs presented for approval at this meeting would be used by this special team. Dr. Sorrell said that the Tox Box was present for approval as a *Special Purpose* or local option drug. He did not expect that the whole state would want to use this and does not expect the state to require the entire state to train for its use.

There was discussion about how the state currently monitors training of drugs. Dr. Norcross suggested documentation of training on the use of Special Purpose Drugs be submitted to the DHEC-EMS Section. Dr. Sorrell recommended documentation be submitted on a yearly basis. Dr. DesChamps said that the training should be documented in the services' records. Currently, Dr. Baker said, there is no special notification sent to DHEC when a service decides to use a local option drug. Dr. Norcross expressed concern that the drug training will not be monitored. Dr. Sorrell suggested that yearly updates on special purpose drug training could be a requirement.

Dr. Norcross made a motion that any EMS provider using the Special Purpose Drug List must provide documentation of yearly training on the use of these drugs. Dr. Rogers seconded the motion. All were in favor. The motion passed.

Dr. Norcross made a motion to approve the toxicology drug box . Dr. Malanuk seconded the motion.

Dr. Baker asked if all new drugs have to be approved by the Medical Control Committee. Dr. DesChamps stated that each drug has to be approved by the Committee. Dr. DesChamps stated that the Committee needs the standard dosage and route of administration for each drug in the Tox Box (that information was not available at the meeting). Dr. Gerard added that the drugs in the Tox Box are potentially dangerous and should be restricted for use with on-line orders.

The members agreed that staff could poll them by fax once the individual drug dosage outlines are provided by Charleston County EMS. Mr. Fanning said the Tox Box cannot be taken to the DHEC Board until the dosages and administration are determined.

Dr. Norcross amended the motion to approve the concept of the toxicology drug box pending fax approval by a majority of the Medical Control Committee of each drug, its dosage and route of administration. Dr. Baker seconded the motion. All were in favor. The motion passed.

Adult Rectal Administration of Valium

Mr. Warren asked the Committee to approve rectal administration of Valium/Diazepam in adults. He explained that rectal administration would be used when IV access can not be obtained and transport time is prolonged. Mr. Warren stated that Diazepam would only be administered with a direct on line order from medical control.

Dr. Sorrell stated that dosage would have to change to 10 mg initial maximum on a single adult dosage. Dr. Baker suggested initial maximum dosage of 10 mg, which may be repeated two times by approval of on-line medical control. The total maximum dosage should not exceed 30 mg.

Dr. Sorrell made a motion to approve the use of Diazepam with the restrictions that 10 mg maximum be given on initial dosage. Dosage may be repeated two times by approval/request of on-line medical control. Total maximum to be given should not exceed 30 mg. Dr. Baker seconded the motion. Dr. Norcross abstained. The motion passed.

Staff explained that, since this is a change in use and not a new drug, approval of this route of administration would not have to go to the DHEC Board.

REVISED INTERFACILITY DRUG TRANSPORT FORM

Dr. Norcross informed the Committee that upon speaking with the director of Medicare, he was informed that the Interfacility Drug Transport form is not being completed/or completed in its entirety. Dr. Norcross recommended that a Physicians Drug Reference book be required on each ambulance to assist medics with unfamiliar drugs.

There was much discussion regarding whose responsibility it is to educate the EMT-P's about the drugs being transported.

Dr. Sorrell stated that the transferring hospital is liable for the patient until he/she is at the next service and therefore should be required to complete the form. Dr. Shelton suggested that services receive more education/training on the importance and how to complete the new form.

Dr. Baker suggested DHEC staff send a letter to each hospital informing them of the importance of completing this form and patient liability.

Mr. Fanning informed the Committee that this form has not been approved by the DHEC Board and can not be used until that time. He added that a memo will be distributed to each service informing them to use the previously approved procedure for transport of patients using interfacility drugs. This means that the list of approved drugs for interfacility transport would be reinstated and the old interfacility transport form would be used.

Dr. Sorrell suggested adding a notification to the bottom of the form stating that this form must

be completed and signed or the patient will not be transported to the next facility. He added that if the hospital refuses to complete the form, the EMT can note (at the bottom) that the hospital refused to complete the form.

Dr. Norcross suggested changing the form to:

1. List the drugs and drug dosage.
2. Add, "Contact (name) and (number) if problems occur".
3. Have nurse signature section.

Dr. Malanuk stated that the last sentence on this form (*The sending physician is responsible for informing the EMT-P of the effects of this drug on this patient, to include adverse/untoward reactions.*) should be removed if the physician signature is not required.

Dr. Baker made a motion to approve the use of the revised list the following changes:

1. **List the drugs and drug dosage.**
2. **Delete "Call if"**
3. **Change the last sentence to read: "The sending facility is responsible for assuring stabilization of the patient prior to transport."**

Further discussion ensued.

Dr. DesChamps suggested tabling this issue until Mr. Fanning reports to the Board the request for approval on the use of this form. *Dr. Norcross suggested a committee be developed to review the Interfacility Drug Transport form and report their recommendation(s) to the Medical Control Committee for final approval. The Committee agreed. The members of the Ad hoc Committee to review the Interfacility Drug Transport Form are: Dr. Carol Baker, Dr. John Sorrell and Dr. Doug Norcross.*

PILOT PROJECTS

Life Reach/Laurens County-Difficulty with Hospital QI Issue

Dr. DesChamps informed the Committee that the Advisory Council approved the pilot projects for Life Reach and Laurens County with the requirement that they obtain letters from the hospital(s) to which they primarily transport agreeing to participate in the projects' QA/QI process.

Dr. Bob Mearns, Medical Control Director of Laurens County EMS reported that Laurens County Hospital would not agree to assist with the quality improvement for the Continuous Positive Airway Pressure project.

Kelly Hawsey of Life Reach reported that although she has received a positive response from other hospitals, Richland Memorial Hospital (where a majority of the patients would be

transported) would not agree to assist with the Cricothyrotomy Pilot Project. She explained that the trauma team at Richland Memorial Hospital strongly feels that this procedure should be done by a trauma surgeon or a emergency physician.

There was a consensus agreement that the Life Reach (cricothyrotomy pilot project) and Laurens County EMS (CPAP) will be unable to proceed with pilot projects because of lack of agreement by hospitals to participate in QI.

Report on RSI

Dr. Gerard informed the Committee that the project has a 92% success rate and the QA process is very effective. Dr. Gerard asked that RSI be open for statewide participation.

Dr. Baker stated that if RSI is approved for statewide use, QA/QI data reports should be submitted for review.

Dr. Fuerst made a motion to allow other services to conduct RSI pilot projects for EMT-Ps. Services wishing to participate must submit a letter stating so DHEC, must use the Lancaster Co. QI tool, and must be approved by the Medical Control Committee.

Dr. Norcross asked who would evaluate the data reports. Dr. DesChamps stated that the RSI subcommittee, chaired by Dr. Gerard, would evaluate all QI data reports. Dr. DesChamps suggested that a representative from Lancaster County assist the subcommittee with the evaluation of the reports.

Dr. Fuerst withdrew his motion.

Dr. Norcross made a motion that RSI be a statewide optional skill at the local level for EMT-P's, with training identical to that of Lancaster County. Services wishing to participate must submit a letter to DHEC prior to training. Participants must submit a QI data report to the RSI subcommittee every six months. The minimum age for administration would be 18 years. Dr. Baker seconded the motion. The motion passed.

Dr. Baker suggested that staff develop a packet based on Lancaster County's pilot project which would include training guidelines, guidelines for RSI use and QI tools for distribution to services who wish to use RSI as an optional skill.

Consideration of Cricothyrotomies as a State skill

There was a consensus agreement that the RSI subcommittee would review the issue of allowing cricothyrotomies as a state skill. The subcommittee will report their findings to the Medical Control Committee for further review/approval.

The Committee agreed to change the RSI subcommittee's name to the Airway Management Subcommittee.

FIELD DEATH PRONOUNCEMENT CHANGES

Dr. DesChamps and Mr. Smith informed the Committee that during a recent investigation of EMT's who did not resuscitate a trauma-asystole patient, it was determined that a state approved Field Death Pronouncement protocols should be developed.

Mr. Smith referred the Committee to the handout of the proposed field death pronouncement protocol. He explained that "Coroner" has been included in item number three, and items four through six have been added after discussion with EMS staff.

Dr. Norcross recommended deleting item number four. He explained that this is covered by the DNR order (item number six).

Dr. Sorrell suggested deleting number five. He explained that a period of time (10+ minutes) can not be adequately determined in the field. The Committee agreed.

Dr. Fuerst made a motion to accept the Field Death Pronouncement Guidelines with the following changes:

1. Add "Coroner" to item #3
2. Delete item #4 and #5
3. Add item #6 as #4

Dr. Shelton seconded the motion. The motion passed.

FIELD TERMINATION OF CARDIOPULMONARY RESUSCITATION

Dr. Fuerst presented papers outlining situations when termination of CPR in the field should be acceptable. The Committee agreed that education is needed to let EMT's and other medical personnel know that it is all right to discontinue CPR in the field. There was a consensus that Dr. Fuerst would draft an article to be submitted to the South Carolina Medical Association Journal (SCMA) and the South Carolina Emergency Physicians (SCEP) regarding the protocol for field termination of cardiopulmonary resuscitation.

REVIEW OF ISSUES RELATED TO THE CRITICAL CARE PARAMEDIC COURSE

Mobile Care

Dr. DesChamps informed the Committee that Scott Lesiak of Mobile Care stated that in the skills previously approved for the Critical Care Paramedic Course, balloon pumps and titration of drips were not included.

Dr. Baker made a motion to approve the critical care paramedic course with all the skills

taught in the Maryland course. The skills used in the CCP project/program will be at the discretion of the local medical control physician. Dr. Shelton seconded the motion. The motion passed.

Meducare, Roper and Spartanburg EMS

Dr. Sorrell informed the Committee that it appeared that without letting any more services participate in the CCP project, there will not be enough students available to put on the CCP course in the Low Country. There was discussion about restricting the course to the two original services which had requested it (Mobile Care and Rural Metro). According to Dr. Sorrell, Meducare, Roper Lifelink and Spartanburg Co. EMS have shown an interest in participating and would fill the course and make it possible for Rural Metro to institute its project. The Low Country course runs for four weeks or more, instead of the more concentrated course of two weeks which was offered by Mobile Care. The length of time required for the course makes it more difficult to locate participants who can attend.

Dr. Baker made a motion that Meducare, Roper and Spartanburg County EMS services be allowed to submit and application to participate in the CCP Pilot Project. Dr. Sorrell seconded the motion. Dr. Norcross abstained. The motion passed.

STERNAL IO

Mr. Lewis Moore with Spartanburg Co. EMS demonstrated the new sternal IO technique and asked the Committee to approve its use.

Dr. Norcross stated that because this would be considered a research project, he would be reluctant in approving its use. There was lengthy discussion during which it was unanimously agreed that Mr. Moore will report back to the Medical Control Committee with a report from the sponsoring hospital's Institutional Review Board (IRB).

The Committee asked staff to contact the DHEC Legal Department for a comment on the need for an Internal Review Board for research projects in the field.

COLLETON COUNTY PEDIATRIC ISSUE

Mr. Smith informed the Committee that a pediatric hemophiliac patient is moving to Walterboro and has asked permission for EMS to be able to administer intravenous Recombinant Factor VIII (Kogenate). Mr. Smith explained that Colleton County is asking if this is qualified under "patient assisted medications."

Dr. Gerard suggested that the child's pediatrician be contacted. Dr. Sorrell volunteered to contact the pediatrician. The Committee agreed. It was decided that Dr. Sorrell will confer with the pediatrician and report his findings back to the Committee.

Because of the late hour, it was agreed that all remaining items on the agenda would be postponed until the next Medical Control Committee meeting. The meeting was adjourned by Dr. DesChamps.

MEDICAL CONTROL COMMITTEE

May 18, 1999

Minutes

Members Present:	Others Present:
Dr. Ed DesChamps, Chairman	Al Futrell, DHEC
Dr. Richard Rogers	Ryon Watkins, Pee Dee Regional EMS
Dr. Carol Baker	Charles Stewart, Lee Co. EMS
Dr. Bob Malanuk	Russ Brahmer, Greenville Co. EMS
Dr. Bill Gerard	Scott Lesiak, Mobile Care Ambulance
Dr. Ron Fuerst	Dr. Tom Ashley, Spartanburg Reg. Med.
	Renee Callan, Mobile Care Ambulance
	Dave McDonald, Mobile Care Ambulance
	David Miller, RN, Hilton Head Hospital
	Janice Hutson, RN, Carolina Pines Hosp.
	Cheryl Douglass, RN, Carolina Pines Hosp.
	Phyllis Beasley, DHEC, EMS
	Joe Fanning, DHEC, EMS

At the beginning of the meeting, there was not a quorum available. The agenda was rearranged to address agenda items which would not need a vote.

DISCUSSION: MULTIPLE PATIENTS/MULTIPLE HOSPITALS

Dr. DesChamps explained that this issue was brought up for discussion because of instances which are occurring more often in which an ambulance may pick up more than one patient. One patient is delivered to a particular hospital, but the other patient, because of insurance policies, etc., then has to be delivered to a different hospital. This situation has brought concerns about COBRA violations. Dr. DesChamps asked for advice, discussion about this by Committee members.

Dr. Baker and Dr. Gerard said that their hospitals have reviewed this issue and that if a patient is anywhere on the hospital campus, then they are considered a patient. Dr. Gerard suggested that the HCFA regional office should provide a clarification and that the Medical Control Committee should write a letter requesting this information. Dr. Baker and Dr. Gerard understood that the patient which wants to leave has to sign a waiver saying that they refuse an exam. *Dr. DesChamps asked Mr. Fanning to write a letter from DHEC requesting this information.*

DISCUSSION: ASSISTANT/ASSOCIATE DIRECTORS FOR SERVICES

Dr. DesChamps said that the issue has come up in instances when a service has lost its director and did not have a replacement who had attended the MCP Workshop. This creates a problem primarily for those services which conduct in-service training for recertifications. Can a service have an assistant/associate medical director in case of instances like this?

Dr. Gerard asked if a service could have two medical directors on the form sent to DHEC? Mr. Fanning said that there would need to be a primary, with a secondary, rather than two medical control physicians.

Mr. Fanning said that staff would research this issue and would come back with a recommendation and a procedure for the Committee.

DISCUSSION: SINGLE MEDICAL DIRECTOR FOR LARGE MULTI-COUNTY SERVICES

This was an issue requested for the agenda by Dr. Sorrell and Dr. Shelton. However, neither Committee member was present at this meeting, so discussion was postponed.

TIMETABLE/PROCEDURES FOR RECERTIFICATIONS OF MCP'S

Dr. DesChamps said that methods for recertification which had been preliminarily discussed were: attend another MCP Workshop, informational meetings, attend other Committee meetings, videos, internet topics. He asked when these options should be ready for use.

The satellite broadcasts were mentioned as a means to recertify. Dr. DesChamps asked if at least one two-hour slot were available for this. Dr. Gerard said the schedule of topics was pretty full. Dr. DesChamps said that even if the satellite broadcast weren't done, which may not be practical anyway, then a videotape could be made by DHEC media department. Dr. Gerard suggested that the workshop could be taped, too. The videotapes could then be distributed by the EMS regions. Ms. Beasley mentioned that the Workshop Revision Subcommittee was meeting later in May and would fine tune these suggestions and bring that information back to the Committee at its next meeting.

PROBLEM WITH CME'S FROM MCP WORKSHOP

Dr. DesChamps said that in the past, we had been able to offer four hours CME to physicians who attended the MCP Workshop at the EMS Symposium. However, this year there was some confusion about it and there are no CME's available. Ms. Beasley said that in the memo which went out recruiting physicians to attend the workshop, 4 hours SCCEP CME's were offered. Ms. Beasley suspected that there were several physicians who had attended the workshop before and who attended again just for the CME credit. She asked the Committee if they would be willing to grant the physicians who attended the 1999 workshop and were promised the CME's a waiver of the first year of recertification requirements. The Committee members present agreed that this would be okay; but would have to bring it up for a vote later when there was a quorum, or conduct a mail vote if necessary.

REPORT FROM MEETING OF REGIONAL MEDICAL DIRECTORS

Dr. DesChamps said that one of the issues discussed was to allow more authority/oversight to regional MCP's for services in their area. He asked if that was something the Committee wanted to do and how. Dr. Gerard said that he was still uncertain about that and the issues surrounding it. Dr. Baker asked if it would take legislation. Mr. Fanning said that legislation might be required if more authority is desired. Dr. DesChamps said that the meeting addressed more day to day involvement. Mr. Fanning said that it would probably require legislation for authority and for money to support this additional activity.

Dr. DesChamps said that at the Trauma Committee that morning, there had been discussion about increased involvement of regional trauma directors and regional EMS directors, both medical and administrative, in conducting outreach activities, particularly on issues such as trauma bypass. He mentioned that this discussion initiated because of the issue of bypassing trauma transports to Grand Strand, after they announced resignation from the trauma system. He said that this type issue would be an educational activity that, ideally, regional medical directors would be involved in.

He asked for suggestions on increase involvement of regional directors. Dr. Baker said this was done several years ago when regional medical directors went to various areas in their regions to develop the regional trauma plans.

There was much discussion about trauma transports and referral patterns.

Dr. DesChamps asked for any further comments on Agenda Item Number 10 which includes the issues:

- < EMD Certification for all 911 operators, training and oversight by DHEC EMS
- < Strengthen MCP position (see discussion above)
- < Change the MCP course
- < Increase responsibility of regional EMS medical directors
- < Establish 13 regional EMS offices.

Dr. DesChamps asked Mr. Fanning to comment on his recent meeting regarding EMS dispatch. Mr. Fanning met with the organization NENA which has dispatchers as members. They are willing to conduct a survey on the status of dispatch in the state, i.e. what office does the dispatcher work from? What types of training do the dispatchers have? He said that once this information is available people would be more willing to make a change. He said that NENA will conduct this survey. Then a strategy for change can be developed. Some EMS-C money has been available in the past for dispatch training.

There were no comments from the Committee regarding other ways to tackle this issue. Mr. Fanning said he would report back to the Committee with information from this survey.

Dr. Malanuk brought up the issue again of Grand Strand withdrawing from the trauma system and the lack of punitive methods. He felt that this action would reduce the effectiveness of the whole trauma system. Mr. Fanning said that in Florida several years ago several hospitals withdraw from the system because of the cost. He said that here, as Grand Strand is withdrawing, Carolina Pines is coming in. He said that he hoped that this withdrawal was not the beginning of a trend. Dr. Malanuk said it would be if there is no penalty for withdrawing and the hospital still receives trauma patients. He said that there is then no reason to jump through the hoops necessary to maintain trauma center certification. Mr. Fanning said that the only way there would be repercussions is if a trauma case "goes sour" and lawyers get involved. Dr. Malanuk asked if Horry Co. EMS could be liable if they take a trauma case to a nontrauma center hospital and the patient has a bad outcome. Dr. DesChamps said that the EMS probably would be liable. Dr. Malanuk said that this is even more reason why DHEC should develop a policy about trauma bypass. Mr. Fanning said that until there is legislation a policy like this cannot be instituted; only a policy statement can be issued.

Dr. Malanuk said that public awareness and public relations are the only means we have for keeping hospitals interested in staying in the system. Dr. DesChamps said that it is up to the medical control physician to have trauma transport protocols that allow only for transport to a trauma center; then hospitals pay attention to the issue. Mr. Fanning said that the DHEC Board would not accept a dictum from EMS on where patients should be taken. He said that perhaps we should begin work on legislation, but in the meantime see what can be done to make the regional trauma plan work without legislation.

Mr. Fanning said that perhaps information should be given to the media in a carefully worded statement from the Medical Control Committee. Ms. Beasley suggested that a news release be issued with a positive statement about the hospitals which have been redesignated and then mention the hospitals which have dropped out. Dr. Malanuk suggested a phone call to the newspaper's health reporter with an inquiry about this issue. Dr. Baker agreed that public relations are the main reason hospitals are in the trauma system. Mr. Fanning asked for a statement, a position, from the Medical Control Committee regarding this issue. Dr. DesChamps said that if a policy statement is adopted about trauma transports; does this become a legal standard? Mr. Fanning said that if the Committee would develop this, then he would take it to

the DHEC lawyers and ask. Dr. DesChamps said that a quorum is needed to develop a policy statement.

Dr. Fuerst arrived and a quorum was met.

Dr. DesChamps said that the MCC should develop such a policy statement as soon as possible. Dr. Malanuk suggested extracting the statement directly out of the ACS standards. The Committee reiterated that the ACS Triage Decision Scheme has already been adopted by the EMS Advisory Council and is considered a standard of care. No further action or decisions on this issue were made.

There was no further discussion on any of the issues mentioned above.

MINUTES FROM MARCH 1999

There were no comments or changes from those minutes. Ms. Beasley noted that Drs. Shelton and Fuerst's names should be added as attendees. The minutes stand as approved.

TRAUMA SYSTEM COMMITTEE ITEMS

LEVEL III TRAUMA CENTER REDESIGNATIONS (AIKEN, TRIDENT, CONWAY, HILTON HEAD, BON SECOURS):

Dr. DesChamps said that several hospitals were considered for redesignations as "re-reviews." Each of the hospitals had minimal changes to make to final their redesignations as Level III hospitals. The Trauma Committee approved those changes in a meeting prior to Medical Control Committee. **Dr. Malanuk made a motion to accept the recommendations of the Trauma System Committee to grant final approval to the following hospitals for redesignation as Level III trauma centers: Aiken Regional Medical Center; Trident Health Systems; Conway Hospital; Hilton Head Hospital; Bons Secours St. Francis Hospital. The motion was seconded by Dr. Baker. The motion passed.**

LEVEL III DESIGNATION OF BYERLY/CAROLINA PINES HOSPITAL:

Dr. DesChamps said that the Trauma System Committee also had made a recommendation to approve Carolina Pines Hospital (formerly known as Byerly Hospital) as a Level III trauma center under Redesignation Option #1 (*"To designate the hospital as a trauma center. The hospital has everything required and is designated with no questions or problems."*) Dr. DesChamps said that the comments from the Trauma System Committee was that this hospital had done as good a job as any Level III in their initial efforts to qualify as a Level III trauma center.

Dr. DesChamps commented that the team had actually conducted the review at the site of the old Byerly Hospital, but had toured the new facility which became operational a week after the

review. The recommendation for Level III trauma center designation would be effective for the new Carolina Pines Hospital.

Dr. Malanuk made a motion to accept the recommendation of the Trauma System Committee to designate Carolina Pines Hospital as a Level III trauma center under Designation Option #1 (“To designate the hospital as a trauma center. The hospital has everything required and is designated with no questions or problems.”) The motion was seconded. The motion passed with one abstention (Dr. DesChamps).

TRAUMA REGISTRY DEFINITIONS:

Dr. DesChamps presented the proposed trauma registry definitions which included one change (see bolded area in the definitions below). The definitions were developed by the Trauma Association of South Carolina and approved by the Trauma System Committee.

- < All injury related deaths pronounced in the emergency department (even if no interventions performed), dead on arrival or died after receiving any evaluation or treatment, during hospital admission.
- < All patients with at least one injury ICD-9 diagnosis code between 800.0 and 959.9, 910-924 (blisters, contusions, abrasions, and insect bites), 930-939 (foreign bodies) and who were admitted and sent *anywhere but* home from the ED.
- < Inclusion of •late effects of injuries• ICD-9 905-909, re-admissions to hospital should be decided upon by your institutional trauma director.
- < Exclude from the registry: Patients 65 years or older with isolated hip fractures, acetabular or femoral neck fracture, ICD-9 820-820.9 with an E-code of E885 and E888 fall on same level, bumping against object or accidental fall.
- < Exclude drowning, near drowning and hangings

The Committee asked that “Exclude” drownings, etc. should be changed to “include” drownings, etc. Ms. Beasley called Jay Hamm, former TASC president to ask the reason for exclusion of drownings.

“TOX BOX” DRUGS

While Ms. Beasley was absent from the meeting, Dr. DesChamps asked Alonzo Smith to brief the Committee on the Tox Box status. Mr. Smith said that the EMS Advisory Council had approved the “Tox Box” in theory and that the Medical Control Committee must now approve the individual drugs within the Tox Box. Dr. DesChamps pointed out that when these drugs are taken to the Board, they should be presented as a group so that they can be approved or disapproved as a group.

Dr. Baker made a motion to approve all the drugs in the Tox Box in the separate section of the Drug Formulary as special purpose drugs with a memo containing information that use of these and other special purpose drugs is a local option and training and yearly updates must be conducted. Dr. Rogers seconded the motion. The motion was approved.

Dr. Baker said that there was a problem with no maximum dose on Atropine in the RSI protocol. Ms. Callan stated that Atropine was part of the protocol in RSI in cases of bradycardia. **Dr. Baker made a motion to remove Atropine as required from the RSI protocol, but can be used in cases of bradycardia. Dr. Fuerst seconded the motion. The motion passed.**

INTERFACILITY DRUG FORM/ISSUE

Dr. Baker asked where we are on that issue. Mr. Smith said that the MCC wanted a subcommittee to meet with DHEC legal staff to hash out medical and legal concerns and reach an understanding of wording for the form. Mr. Smith said that we are back at using the interfacility drug list. There was much discussion about the need to transport with more drugs and overloading EMT-P's with too many drugs to learn. Dr. Baker, Dr. Sorrell and Dr. Norcross are on the subcommittee to examine this issue. Dr. Baker asked that the group and legal staff meet prior to the next Medical Control Committee meeting.

WORKSHOP CME'S

Since there was now a quorum, Dr. DesChamps returned to the issue of allowing the physicians who attended the February 1999 MCP workshop to be exempted from the first year MCP recertification requirement, since a misunderstanding will prevent them from being awarded CME's for attending the workshop. **Dr. Malanuk made a motion to allow the physicians who attended the February 1999 MCP Workshop at the EMS Symposium to count that as their first year recertification requirement. The motion was seconded by Dr. Rogers. The motion passed.**

TRAUMA REGISTRY DEFINITIONS

The Committee referred back to the issue of the trauma registry definitions and the question about whether to include drownings. Ms. Beasley said that she was unable to reach Jay Hamm of TASC to clarify the organization's reasoning on this issue. She said that she remembered that TASC wanted to stay as close to ACS guidelines as possible. Dr. DesChamps asked if the Committee wanted to vote on these definitions or wait till they could have input from a member of TASC. Dr. Malanuk said that he felt numbers from drownings and hangings would not be overwhelming and he was in favor of keeping those patients in the registry. **Dr. Malanuk made a motion to change the trauma registry definitions to include drownings, near drownings and hangings. Dr. Rogers seconded the motion. The motion passed.**

PHENERGAN

Ms. Callan asked for clarification on the use of phenergan. She said that the drug formulary shows that the drug can be used, but must be administered by the hospital and can only be transported by EMS. Mr. Smith and Dr. DesChamps clarified that Phenergan has been changed to a prehospital use drug, but the change has not been made in the drug formulary book. It is permissible to use that drug in the prehospital setting.

TRAUMA SYMPOSIUM

Dr. DesChamps announced that the next TASC-sponsored Southeastern Trauma Symposium is scheduled for October in Greenville. He also said that TASC has a website now: www.trauma-sc.org.

NEXT MEETING

Dr. Baker asked that a pilot project for Greenville County be considered. (Topic could not be heard from tape.)

Dr. Baker also asked when RSI could be implemented statewide. Dr. DesChamps said it would be August before the RSI drugs could be approved by the DHEC Board.

AGENDA ITEMS NOT ADDRESSED AT THIS MEETING:

- < Discussion: Single medical director for large, multi-county services (Drs. Sorrell and Shelton)

AGENDA ITEMS PROPOSED FOR NEXT COMMITTEE MEETING:

- < (Dr. Baker) Pilot project (?) for Greenville County

AGENDA ITEMS NOT RESOLVED/CONCLUDED AT THIS MEETING:

- < Report from meeting of Regional Medical Directors re:
 - a. EMD Certification for all 911 operators, training and oversight by DHEC EMS
 - b. Strengthen MCP position
 - c. Change the MCP course
 - d. Increase the responsibility of regional EMS medical directors
 - e. Establish 13 regional EMS offices
- < Discussion: Multiple patients/multiple hospitals
- < Discussion: Assistant/associate directors for services

STAFF REPORTS/ACTIONS DUE AT NEXT MEETING:

- < Mr. Fanning to write a letter from DHEC to HCFA regional office requesting a clarification on issues of COBRA violations when an EMS service delivers one patient to one hospital and leaves to take its second patient to a different hospital.
- < EMS staff to research the issue of what would be necessary to have assistant/associate directors for EMS services
- < Mr. Fanning to report with the results of the dispatch survey to be conducted by NENA.

SUBCOMMITTEE ACTION NEEDED:

- < Drs. Baker, Sorrell and Norcross to meet with DHEC legal staff immediately prior to the next Medical Control Committee to resolve interfacility drug form concerns.

RESOLVED ISSUES FOR THE FIELD SHOULD BE NOTIFIED:

- < Staff to write a memo to the field reiterating the adoption and importance of the ACS Triage Decision Scheme.
- < Memo regarding the new trauma registry definitions

MEDICAL CONTROL COMMITTEE

MINUTES

November 18, 1999

Members Present:	Others Present:
Ed DesChamps, MD, Chairman	Casey Bolton, EMT-P
Carol Baker-Burger, MD	Jeff Ward, EMT-P
Doug Norcross, MD	John Rasmussen, EMT-P
Steve Shelton, MD	Mark Pinosky, MD
Bob Malanuk, MD	Tom Ashley, MD
Richard Rogers, MD	Teke Washington
	Phyllis Beasley
	Joe Fanning

The Medical Control Committee was called to order by Dr. DesChamps, chairman.

REVIEW OF 5/18/99 MINUTES

The first item on the agenda was the review/discussion of the minutes from the last Medical Control Committee meeting on May 18, 1999. **Dr. Shelton made a motion to accept the minutes as presented. The motion was seconded by Dr. Baker. All were in favor. The motion passed.**

AIRWAY SUBCOMMITTEE REPORT/DEMONSTRATION OF LARYNGEAL MASK AIRWAY (LMA)

Dr. Norcross stated that the Airway Subcommittee met and discussed allowing cricothyrotomies (*crics*) as a state-approved skill. The use of crics has proven successful in two pilot projects and has been incorporated in the national curriculum. The Subcommittee agreed that cricothyrotomies should be removed from pilot project status and allowed as a state approved skill. The Subcommittee also reviewed the use of LMA's prior to using crics. If the use of the LMA is approved, a training module must developed.

Dr. Mark Ponoski, an Associate Professor of Anesthesia at USC Medical University,

demonstrated the types, use and operation of the Laryngeal Mask Airway.

Dr. DesChamps inquired as to the number of hours needed to train on the use of the LMA. Dr. Ponoski stated that the main focus in training would be on the sizing the LMA to the patient. Overall training would take no more than one day.

Dr. Norcross suggested Charleston County EMS test the use of LMA's as a pilot project.

Dr. Fuerst stated that the LMA is a good device for the operating room but not in the field. He suggested waiting to see what other devices are available before making a decision.

Dr. Norcross stated that his concern is that RSI will be used throughout the state and there isn't a fall back.

Dr. Baker stressed the pros in using the LMA verses performing crics.

Dr. Fuerst asked the Committee to hold a decision until he has received training on the use of the LMA.

There was a discussion regarding the cost of the LMA and how it would affect EMS services.

There was a consensus agreement to table a decision until Dr. Norcross and Dr. Fuerst have been trained on the use of the LMA. They will make a recommendation at the next Medical Control meeting.

TRAUMA CENTER REDESIGNATIONS

Roper Hospital

Dr. DesChamps informed the Committee that Dr. Brian Weaver and David Atkinson, RN were the site reviewers for Roper Hospital. During the review no problems were found and Redesignation Option # 1 was recommended. **Dr. Shelton made a motion to redesignate Roper Hospital as a Level III trauma center under Redesignation Option #1 with final approval to be made by the Advisory Council. Dr. Baker seconded the motion. All were in favor. The motion passed.**

Regional Medical Center of Orangeburg and Calhoun Counties

Dr. DesChamps informed the Committee that Dr. Tom Ashley was the team leader for this site review, Dr. Jim Wright was the emergency physician and David Atkinson was the critical care nurse on this team. There were no major problems were found during the review and Redesignation Option # 1 was recommended and approved by the Trauma Systems Committee. **Dr. Shelton made a motion to redesignate the Regional Medical Center of Orangeburg and**

Calhoun Counties as a Level III trauma center under Redesignation Option #1 with final approval to be made by the Advisory Council. Dr. Baker seconded the motion. All were in favor. The motion passed.

Loris Community Hospital

Dr. Ray Bynoe served as the team leader for Loris Community Hospital site review. Dr. Gerard was the emergency physician and Aline Greene was the critical care nurse on this team. There were no problems were found during the review and Redesignation Option # 1 was recommended and approved by the Trauma Systems Committee. **Dr. Shelton made a motion to redesignate Loris Community Hospital as a Level III trauma center under Redesignation Option #1 with final approval to be made by the Advisory Council. Dr. Baker seconded the motion. All were in favor. The motion passed.**

OLD BUSINESS

Single Medical Director for Large, Multi-County Services

Dr. Shelton informed the Committee that there has been inquiry regarding the need for an associate medical director to assist the primary medical director in large, multi-county services. The associate medical director could observe the training of medics within the region and sign off on the completion of their training. Currently it is difficult for a medical director of a large, multi-county service to observe the training of all medics within his region.

Mr. Fanning stated that the associate medical directors is already in place and is listed on the license for ambulance services. The associate medical director can function of the signature of the primary medical director. If the primary medical director quits or employment is somehow terminated, the associate medical director can serve as the primary medical director. This would allow compliance with what is required to run an IST program.

Multiple Patients/Multiple Hospitals/HCFAs Response

This issue is regarding an ambulance that has transported two patients to a hospital; one patient was delivered to the hospital, but the second patient in the ambulance has requested, because of insurance considerations or personal preference, delivery to a different hospital. Dr. DesChamps informed the Committee that HCFA was asked if the second patient left the original hospital grounds without treatment, would this be in violation of the EMTALA laws. The response was yes, there is a great risk for EMTALA violation by the hospital. Both patients must be evaluated upon arrival at the hospital.

Dr. DesChamps asked that staff distribute notification of HCFA's response to all licensed EMS services. Mr. Fanning agreed.

CLARIFICATION OF REQUIREMENT OF ON-LINE MEDICAL CONTROL PRIOR TO USE OF VERSED IN RSI

Dr. DesChamps stated for clarification that under South Carolina law you must have on-line medical control to administer a “*scheduled*” drug. When RSI is implemented statewide, medical control must be contacted before the initial administering of Versed or any *scheduled* drug. After the initial approval of medical control other *scheduled* drugs listed on the drug formulary can be administered without prior approval.

Dr. Baker stated that this requirement is not necessary for the Critical Care Paramedic program as written orders are given for each specific patient.

INTERFACILITY DRUG SUBCOMMITTEE REPORT

Dr. DesChamps stated that the goal is to eliminate an approved interfacility drug list. This would allow paramedics to transport whatever drugs are necessary for patient care. Education and information on transporting drugs would be given prior to each transport. If problems occurred during the transport, on-line medical control must be notified. The Subcommittee met with the DHEC Legal representatives and has agreed on a form. The Committee reviewed the revised form.

Dr. Baker stated that there were problems getting the sending physician’s signature on the old interfacility drug form. The new form requires a signature from a nurse or designee along with a hospital report on the patient. The receiving paramedic must also sign the new form acknowledging receipt of patient, drugs and instructions. A copy of the interfacility drug form will be given to the nurse or designee for hospital record. The original interfacility drug form will be attached to DHEC patient care form (run report) and the hospital patient report.

Dr. Norcross asked if the FDA notification could be removed.

Dr. DesChamps suggested “or are being used in a manner not consistent with FDA approval” be deleted from the sentence. The new sentence should read: *None of the drugs sent with this patient are part of an experimental program.*

The Committee agreed. *Staff was asked to submit the revised Interfacility Drug Report Form to the DHEC Board.*

NURSE MIDWIVES ON AMBULANCES

Dr. DesChamps stated that a request from the Nurse Midwife Association during the June 1999 Advisory Council was referred to the Medical Control Committee for further consideration. The request is to allow midwives to accompany their patient on an ambulance and assist with patient

care while en route. Dr. DesChamps stressed concerns with determining who would be the authority in charge of the patient and who would be liable if an accident occurs.

For clarification Ms. Byrd stated that the request came from licensed nurse midwives not certified nurse midwives.

Mr. Fanning stated that the request is to allow the midwife to provide comfort while the patient is in transport.

Dr. Shelton stated that if the role of the midwife is to provide comfort, they should follow policy as it relates to family and friends.

Mr. Smith stated that ambulance service policy, as it relates to family and friends, would preclude nurse midwives from riding in the rear. However, they would be allowed to ride in the front.

Dr. Shelton made a motion that nurse midwives follow individual ambulance service policy as it relates to family and friends. The EMT has complete authority in this situation. Dr. Fuerst seconded the motion. All were in favor. There were no abstentions. The motion passed.

PILOT PROJECT PROPOSAL FROM GREENVILLE COUNTY EMS: PREHOSPITAL THROMBOLYTIC THERAPY

Dr. Baker informed the Committee that Greenville County EMS is requesting the approval of a pilot project to use Retavase in the field. Greenville County EMS has had 12 Lead EKG capabilities in place for five years. The experience level is high and paramedics have been well trained. The use of Retavase would be a natural extension of the current program. Dr. Baker stated that Retavase would only be administered with prior approval of on-line medical control, if the 12 Lead EKG results and the patient meets criteria for thrombolytics. There would be ongoing QA for each thrombolytic case. Dr. Baker explained that a four hour training module has been designed to teach the procedure of administering Retavase and the required dosage. Continuing education will be given quarterly.

Dr. Norcross asked if the consent form is needed. Dr. Baker responded that the consent form was included because Retavase is a non routine state approved drug.

After reviewing the November 18, 1999 memo from Nancy Layman, regarding 1999 EMS Policy-Related Questions, and taken into consideration previous pilot programs similar to this, the Committee decided to discard the consent form. Administration of this drug for thrombolytic therapy is not experimental or research.

Dr. DesChamps asked when would the use of Retavase in the field be implemented. Dr. Baker

stated within ninety days after Board approval.

Dr. Shelton asked when progress reports would be given. It was stated that previous pilot project reports are given every 6 months with documentation from participating hospitals.

Dr. Shelton made a motion to approve the pilot project from Greenville County EMS to use Retavase in the field with prior approval from on-line medical control. Progress reports must be given to the Medical Control Committee every six months with QA reports from participating hospitals. Implementation is pending until final approval is given by the EMS Advisory Council and letter of QI participation from the participating hospital(s). Dr. Rogers seconded the motion. All were in favor. The motion passed.

CHANGING MEDICAL CONTROL MEETING SCHEDULE (e.g. Fixed date on a Quarterly Basis)

Dr. DesChamps stated that staff has asked that the Committee consider setting a specific meeting day and time be it monthly or quarterly to help assure a quorum is met for each meeting. This would also help members arrange their schedules to accommodate these meetings. There was a discussion on setting quarterly meetings, or agenda based meetings.

Ms. Beasley stated that the major problem is scheduling conflicts. She suggested quarterly meetings be set and if there are not enough issues for discussion, the meeting could be canceled and issues held until the next quarterly meeting.

The Committee decided to set two trial quarterly meetings with *call checks* the week prior to the meeting. The next meeting will be held at the EMS Symposium on Thursday March 2, 2000 at 3:30 pm. The quarterly calendar will be set at this meeting.

CRITICAL CARE TRANSPORT

Dr. Baker asked the Committee for a recommendation on the following problems encountered by the critical care transport team.

- **PROBLEM 1:**
 - When a tertiary facility is transporting a patient that who has received the first dose of Retavase under the pilot a second dose can not be administered en route.

- **PROBLEM 2:**
 - If a patient on a long distance transport receives medication at a specific time and a second dosage of medicine must be given while the patient is en route, medics are not allowed to restart drugs during transport.

Dr. Baker asked the Committee to consider removing these restrictions from the critical care

transport team.

Dr. Shelton made a motion to add an addendum to the Critical Care Paramedic Pilot Project that medication which continues previous treatment can be administered at the request of the sending physician. The motion was second by Dr. Rogers. All were in favor. There were no abstentions. The motion passed.

MEDICAL CONTROL PHYSICIAN ISSUES

Dr. DesChamps asked the Committee to consider allowing the local medical control physician to accept responsibility and act outside of current guidelines during a declared state of emergency.

Mr. Fanning felt this is a good idea and should be followed up with the Legal Department.

There was discussion regarding whether the emergency for these guidelines would be state or locally declared. It was determined that all circumstances would require a report to the Medical Control Committee for review.

There was a consensus agreement to table the discussion on this issue until the next meeting. *Mr. Fanning was asked to research the law and regulations for more information on this issue.*

MEDICAL CONTROL PHYSICIAN RECERTIFICATION

Ms. Beasley stated that it was previously suggested to allow non-Committee members to serve as members of Subcommittees and receive credit for medical control physician recertification.

Ms. Beasley stated that methods for recertification have been developed but there a lot of things that come up throughout the year that can be added. It was then suggested that recertification for physicians who serve as trauma site reviewers be included to the list. The Committee then reviewed the handout of the summary of the recertification subcommittee.

Dr. Shelton inquired as to trauma site reviewer requirements.

Ms. Beasley stated for clarification that medical control physicians can be recertified for participation in a site review, not just for attending the workshop.

Dr. Fuerst stated that site reviewing does not serve the need of providing awareness of EMS protocol, drug or training changes. He suggested a yearly report of protocol changes be distributed to medical control physicians with a *sign off sheet*. Each physician must acknowledge receipt and reviewing of the protocols by returning a signed copy of the *sign off sheet*.

Dr. Baker suggested that the protocol changes and *sign off sheet* be mandatory.

The Committee agreed that the recertification options approved by the subcommittee will begin this year and the *sign off* protocol summary report will begin next year. Trauma site reviewing will not count toward recertification.

Dr. Rogers made a motion to adopt the methods of recertification as presented with the idea that it can be revised. An annual summary of the protocol changes with a *sign off sheet* acknowledging receipt and reviewing of the protocols should be added. The protocols can be distributed either via mail or internet. Dr. Norcross seconded the motion. All were in favor. There were no abstentions. The motion passed.

Because of the late hour, it was agreed that all remaining items on the agenda would be postponed until the next Medical Control Committee meeting. The meeting was adjourned by Dr. DesChamps.

AGENDA ITEMS NOT ADDRESSED AT THIS MEETING:

- < EMT-B transport of patients on transport ventilators - Dr. Shelton
- < Results of dispatchers survey from NENA (continued from 5/99) - Joe Fanning

AGENDA ITEMS NOT RESOLVED/CONCLUDED AT THIS MEETING:

- < Local medical director authority during disasters - Dr. Shelton
- < Allowing cricothyrotomies as state approved skill
- < Changing MCC meeting schedule
- < Allowing MCP to act outside of current guidelines during disaster

STAFF/OTHER REPORTS DUE AT NEXT MEETING:

- < Drs. Norcross and Fuerst will report on "usability" of LMA's
- < Staff will ask the legal department about MCP authority during disasters

STAFF ACTIONS NEEDED:

- < Memo to the field regarding HCFA's reponse about multiple patients/multiple hospitals
- < Submit revised interfacility drug form to the DHEC Board for approval
- < Notify appropriate persons/agencies about midwife policy resolution